Medical & Religious/Cultural Food Restrictions — Infants

Infant's Name____

Infant's Date of Birth ____________________________Infant's Age ____________

Parent/Guardian's Name (please print) ____________________________________

Parent/Guardian Phone Number: (Home) ___________________________________

(Work) _________________________ (Cell) ____________________________

Today's Date__________________ Special Diet Effective Through_________________

In order to make substitutions for foods required in the CACFP/*Delacare* infant meal pattern, the following information must be provided by a licensed medical professional. The medical professional must note, in writing, a list of the foods acceptable as substitutions.

Please check the statement below which describes your infant's dietary restriction and list the foods that may be substituted.

____ No iron-fortified formula. Please check the desired substitution.

- ☐ Non iron-fortified formula
- ☐ Other _________________________________

____ No iron-fortified infant cereal.

Please list cereals or foods which may be substituted:

____

____

____ Other restriction (please list) ______________________________________

Please list foods which may be substituted:

____

____

____

Medical Professional Name (please print): ______________________________

Medical Professional Signature: ________________________Date ___________

Parent/Guardian Signature ____________________________Date ___________